

Risk Management



Accountable Care Organizations and Professional Liability Risk

by Charles D. Cash, JD, LLM

Innov Clin Neurosci. 2015;12(11–12):26–29

This ongoing column is dedicated to providing information to our readers on managing legal risks associated with medical practice. We invite questions from our readers. The answers are provided by PRMS, Inc. (www.prms.com), a manager of medical professional liability insurance programs with services that include risk management consultation, education and onsite risk management audits, and other resources to healthcare providers to help improve patient outcomes and reduce professional liability risk. The answers published in this column represent those of only one risk management consulting company. Other risk management consulting companies or insurance carriers may provide different advice, and readers should take this into consideration. The information in this column does not constitute legal advice. For legal advice, contact your personal attorney. Note: The information and recommendations in this article are applicable to physicians and other healthcare professionals so “clinician” is used to indicate all treatment team members.

QUESTION

“I work in a large psychiatric practice. The practice owners are considering joining with our local hospital and other physician practices to form an accountable care organization (ACO). If the practice

enters an ACO, what will be the likely effect on my professional liability risk?”

ANSWER

The Patient Protection and Affordable Care Act is the landmark

healthcare reform law that was enacted in 2010. According to the United States Centers for Medicare and Medicaid Services, “The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010, and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name ‘Affordable Care Act’ is used to refer to the final, amended version of the law.”¹

While we do not yet know the ultimate effect of the Affordable Care Act on psychiatrists, we can at least predict a trend toward greater collaboration between them and other clinicians both inside and outside of the mental health field. Payers, both private and governmental, are encouraging collaborative and integrated care models, believing that with increased collaboration and communication, there will be better care delivered and less duplication of services, resulting in reduced healthcare costs.

Under the Affordable Care Act, groups of healthcare providers and hospitals can join together and form ACOs. According to the United States Centers for Medicare and Medicaid Services, providers in the ACO deliver “coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organization’s payment is tied to achieving healthcare quality goals and outcomes that result in cost savings.”²

In ACOs, providers may share in the cost savings associated with improved patient health and the lower cost of care through risk sharing. Risk sharing can follow a shared savings model or a shared risk model. According to Collins and Waxman,³ under the shared savings model, if the “total cost of providing care for the defined population is

lower than the budgeted/targeted level, the ACO shares in a percentage of this savings.” The ACO will not share in the losses if the budgeted/targeted costs are not met. Under the shared risk model, if “the actual costs are below budget the ACO can share in the savings, and if they exceed budget the ACO can share in a portion of the deficit. The percentage of the savings shared by the ACO is higher under the shared-risk model than under the shared-savings model.”³

There may be significant liability exposure related to this incentivized cost containment. What are the professional liability risks for psychiatrists? The professional liability risk will vary depending on the exact model of collaborative care. This article focuses on the impact an ACO may have on medical malpractice litigation. Issues related to forming an ACO or other integrative care model, and the significant associated risks to the entity (e.g., the Stark law, anti-kickback statute, and antitrust issues) are beyond the scope of this article.

IN SOME COLLABORATIVE CARE MODELS, THE ACTUAL LIABILITY RISKS MAY NOT CHANGE

Psychiatrists already can be held liable for the acts of other professionals. In a medical malpractice action, the plaintiff’s attorney has a professional obligation to pursue every possible defendant. This means that a psychiatrist who has been involved, however remotely, in the plaintiff’s treatment can almost always expect to be named as a defendant. Treatment arrangements in which liability for the acts of others has typically been a risk include the following:

1. In split-treatment relationships (where the psychiatrist provides

psychopharmacology and a therapist provides therapy), the liability risks have remained the same since this model was introduced in the managed care era. The psychiatrist has always been responsible for ensuring the patient receives appropriate care. Ultimately, however, the court and the jury will decide what actions and/or omissions of the psychiatrist and nonmedical therapist will be determinative of liability. They may choose to ignore the distinctions on which the professionals functioned.

2. When working with nurse practitioners, whether in a supervisory or collaborative role, the psychiatrist always has increased liability exposure based on the nurse practitioner’s actions or omissions.

Psychiatrists providing true consultations (i.e., not prescribing, not writing orders) will continue to take on minimal liability. The closer the consultant’s specialty and training is to that of the person seeking the consultation, the less risk there is. For example, a child and adolescent psychiatrist providing a consult to another child and adolescent psychiatrist bears far less risk than a psychiatrist providing a consult to a social worker.

Care may be delivered via telemedicine. The risks vary with the remote treatment model used, and may be dependent upon the extent to which the psychiatrists’ lost abilities (such as to hear, see, and smell) can be restored. Additionally, psychiatrists must consider whether they can clear attendant legal and clinical hurdles such as licensure (e.g., care is rendered where the patient is physically located, so the psychiatrist may need to be licensed in the patient’s state) and meeting

the standard of care remotely (i.e., the standard of care for remote treatment is the same as if the patient was in the psychiatrist’s office).

The overall risk may increase.

More people will have insurance. With increased utilization of these collaborative care arrangements, psychiatrists’ overall liability can be expected to increase. In other words, the risk per patient remains as it has historically been, but there may be more patients treated via this care model so the aggregate risk increases.

Suicide and attempted suicide and medication misadventures will remain the greatest risk areas for psychiatrists.

IN NEWER INTEGRATED CARE MODELS, THERE COULD BE NEW LIABILITY RISKS

There are many different types of integrated care models. This article focuses specifically on ACOs, but many other types will follow ACO requirements.

New roles bring new liability risks. With all of the newly insured patients, and the shortage of psychiatrists, psychiatrists who join an ACO may be asked to take on roles beyond direct patient care that they have not previously undertaken. Examples include supervising a nurse practitioner or consulting with pediatricians and primary care physicians (PCPs).

New duties bring new liability risks. The more the practice of medicine is regulated, the greater the liability exposure. For example, ACO providers are required to use patient and caregiver assessments as well as individualized care plans. Failure to use these new required items could be seen by plaintiffs’ attorneys as failure to meet the standard of care, and could be seen by the regulators

as violations of the law, which may result in penalties. As another example, there is language in the law requiring “patient engagement,” particularly in terms of making treatment-related decisions. Specifically, ACOs are required to share clinical information and evidence-based medicine with patients in an understandable way, sharing their medical records and working with patients in shared decision-making.

EHRs bring new liability risks.

Use of electronic health records (EHRs) is a pre-requisite to the mandated sharing of patient information. Examples of liability risks include, but are not limited to the following:

- Information overload
- Alert fatigue
- Responsibility for knowing all information in the EHR
- Inappropriate use of templates/ lack of individualized content
- Metadata, such as time it took the psychiatrist to override an alert or clinical support tool, may be available to plaintiffs’ attorneys.

New requirement of sharing of patient information increases breach risks.

Fundamental to integrated care is the extensive sharing of information through a variety of treatment environments, which will increase psychiatrists’ potential liability exposure for failure to comply with confidentiality and security of patient information requirements. Sharing of information is important not only to ensure all information is considered when making treatment decisions, but also to avoid duplication of expensive diagnostic studies. The more information that is disclosed (particularly electronic patient information), the greater the likelihood of a breach due to

inappropriate access or disclosure as a result of inadequate data security policies. In addition to liability for breach of confidentiality, covered entities under the Health Insurance Portability and Accountability Act (HIPAA) are subject to significant civil and criminal penalties.

THE IMPACT OF ACOs ON MEDICAL MALPRACTICE LITIGATION

Cost containment. If there is a medical malpractice lawsuit brought by a patient treated in an ACO, the plaintiff could allege that a provider’s negligent failure to provide a service—or refer for a service—caused the patient harm and was done to contain costs, given the provider’s risk sharing arrangement. In fact, such a financial incentive to restrict services could lead to alleged punitive damages for intentional wrongdoing, which are not covered by traditional medical malpractice insurance policies. Medical malpractice litigation will likely include reviewing the ACO’s policies on resource utilization and physician compensation.

Given this very real scenario, the risk management advice is—more than ever in such a treatment setting—for psychiatrists to document not only what was done and why, but also what was considered and rejected and why. Such documentation will be crucial to avoid allegations of putting profit ahead of patient safety.

Another aspect of cost containment involves the choice to settle a medical malpractice lawsuit. For example, a psychiatrist who joins an ACO may not have input into when a case against him is settled. The ACO may decide to settle early to prevent incurring expensive defense costs and perhaps a substantial judgment. So there may

be a shift from private practice psychiatrists vigorously defending cases to cases being settled early by the ACO to contain costs.

Standard of care. ACOs are required by Medicare to promote evidence-based medicine, and payment is based on achievement of quality criteria. Some quality criteria could potentially be used to evidence the standard of care in a malpractice case. For example, a plaintiff’s attorney could argue that a psychiatrist’s failure to meet the ACO’s quality criteria is failure to meet the standard of care, which is negligence.

Availability of professional liability insurance in the event of medical malpractice litigation.

Large practices and health systems often are self-insured. A self-insured insurance plan is only as secure as the company’s financial stability. If a psychiatrist’s employer, such as a hospital system, goes into bankruptcy, there could be adverse insurance coverage implications.⁴ When transitioning from private practice to an ACO, psychiatrists should confirm coverage and limits of liability with their employer.

SUMMARY

It is too early to know the ultimate effect of the Affordable Care Act on psychiatrists’ professional liability risk. We can at least predict a trend toward greater collaboration between psychiatrists and other clinicians both inside and outside of the mental health field.

In some collaborative care models, the actual liability risks may not change. For example, psychiatrists in collaborative relationships already can be held liable for the acts of other professionals. Psychiatrists providing true consultations will continue to take on minimal liability. Suicide and attempted suicide and

medication misadventures will remain the greatest risk areas for psychiatrists.

In newer integrated care models, there could be new liability risks. For example, new roles and duties and the use of EHRs bring new liability risks. Sharing of patient information increases the risk of breaches.

Financial incentives in risk sharing arrangements also could be used by plaintiffs to allege that failure to provide a service was done to contain costs. Some quality criteria could potentially be used to evidence the standard of care in a malpractice case. A plaintiff could argue that a psychiatrist's failure to meet the ACO's quality criteria equates to failure to meet the standard of care. The risk management advice is for psychiatrists to document carefully not only what was done in treatment and why, but also what treatment options were considered, but rejected, and why.

REFERENCES

1. United States Centers for Medicare and Medicaid Services website. Glossary. Affordable Care Act <http://www.healthcare.gov/glossary/affordable-care-act>. Accessed December 1, 2015.
2. United States Centers for Medicare and Medicaid Services website. Glossary. Accountable care organization. <http://www.healthcare.gov/glossary/accountable-care-organization>. Accessed December 1, 2015.
3. Collins C, Waxman JM. *MMS Guide to Accountable Care Organizations: What Physicians Need to Know*. Massachusetts Medical Society. September 2013. <http://www.foley.com/files/Publication/59de54ad-4877-4cd6-9bfb-d78177f8452b/Presentation/PublicationAttachment/5b2ba4fa-d727-41ffb8a5-da3e5bee79b6/ACOGuide%20-%20FINAL.pdf>. Accessed December 1, 2015.
4. Hartocollis A. Troubled New York hospitals forgo coverage for malpractice. *New York Times* website. July 15, 2012. <http://www.nytimes.com/2012/07/16/nyregion/some-hospitals-in-new-york-lack-a-malpractice-safety-net.html>. Accessed December 1, 2015.

AUTHOR AFFILIATION: Mr. Cash is Assistant Vice President of Professional Risk Management Services, Inc. in Arlington, Virginia.

ADDRESS FOR CORRESPONDENCE:

Donna Vanderpool, MBA, JD,
Vice President, Professional Risk
Management Services, Inc., 1401 Wilson
Blvd., Suite 700, Arlington, VA 22209;
E-mail: vanderpool@prms.com

SUBMIT YOUR OWN QUESTION

To submit a question, e-mail Elizabeth Klumpp, Executive Editor, eklumpp@matrixmedcom.com. Include "Risk Management Column" in the subject line of your e-mail. All chosen questions will be published anonymously. All questions are reviewed by the editors and are selected based upon interest, timeliness, and pertinence, as determined by the editors. There is no guarantee a submitted question will be published or answered. Questions that are not intended for publication by the authors should state this in the e-mail. Published questions are edited and may be shortened. ■